# Chapter 5: The Realities of Nurses

As already discussed, healthcare is provided by the state as well as non-state actors including both the private for-profit sector and the private not-for-profit sector. However, healthcare, in reality, is provided by individuals or healthcare workers like nurses and their realities, conditions in which they do their work, severely affect how healthcare is delivered at the ground level. However, it is important to proceed with a word of caution. There is no single, category of nurses, and that the world of nursing like any other profession is hierarchical in nature.

The word 'nurse' is derived from the Latin word *nutrire*, meaning to nourish (Theofanidis and Sapountzi-Krepia 2015, 793). Development of 'modern' nursing in India is linked with the idea of Western industrial modernity and its long association with religious sisterhoods has impacted the profession as it was perceived to be based on a 'Christianised discourse of obedience and service' (Healey 2013, 4). The 'earliest type' of 'modern' nurses, in the Indian context, can be found in military service. When a hospital at St. George Fort, Madras started functioning for the soldiers of the East India Company, the first batch of sisters arrived from London's St. Thomas Hospital (Jayapal and Arulappan 2020, 2). But the history of nursing in India can be traced back to 1500 B.C. Susruta, a famous ancient physician, compared the relation between the doctor, nurse, medicine and patient, to the four feet on which cure (or care) depends (TNAI 2001, 1-4).

Before we begin, it is important to mention that discussions on healthcare or healthcare policies give more attention to the role of doctors while providing healthcare. Though what the doctors do, is of great importance and relevance however much of the discussions on healthcare centres around the role, opinions, problems of doctors and discussions on other categories of healthcare workers get marginalised. If one looks into the three National Health Policies framed by various governments, across time, in India, then one can find that in terms of overall recommendations, doctors received preference over nurses, auxiliary nurses, midwives, and pharmacists (Jungulwalla Committee 1967; GOI 1983; Nundy, Desirajuand Nagral, 2018; Davalbhakta et. al. 2020; Dubey, Vasa, Zadey 2021). This 'lack of focus' on nurses necessitates highlighting the case of nurses in providing healthcare.

## 5.1 Early developments:

Chapter nine of *Charaka-Samhita* stated that an ideal nurse[1] should be the one who would have the right knowledge as to how medicines have to be administered to the patient. The nurse should be intelligent, devoted to the patient and pure (in terms of body and mind). These were the required qualities of a nurse (TNAI 2001, 4). With the rise of Buddhism between 500 B.C. and 300 AD many hospitals were built by Ashoka (in India) and King Buddhadasa (of Sri Lanka) who had initiated a state medical system with a doctor being appointed for every ten villages. Between 250 B.C. and 750 A.D. there was advancement in the practice of medicine and saw nursing to be practiced by women, within their households while they cared for the sick and old members of the family. In institutions it was done by older women and men. Some suggest that with the Mughal invasion, the medieval period was characterized by the absence of female nurse. Various reasons like the practice of purdah, rigid caste system, growing illiteracy, political unrest etc. led women to retreat from this space (Bagga et.al. 2013, 12).

It also needs to be highlighted here that less focus on discourses on hospitals, caring or nursing during the medieval period is the result of a bias towards western scientific medicine. This biasness led many to believe that hospitals during the medieval period were religious or charitable in nature where attendants did not require special knowledge. Such a view gave primacy to the role of physicians and disregarded the fact that before the onset of twentieth century, other health care workers often overshadowed the physicians. In the west, exclusion of women from universities gave advantage to male physicians who had access to important medical treatises and thus made the positions of female healers and nurses less important during the twelfth and thirteenth centuries (Bullough and Bullough 1993).

Further, it needs to be reiterated that though nursing is associated with women, male nurses have been present in history to the present time. Situations like wars or nurse shortages often blur the gender angle. The very construction of masculine identity has also hindered men from joining this profession. It was during the last decades of the 19$^{th}$ century, that Indian women started entering the medical profession and it was one of the earliest professions that saw Indian women participating in. The demand for British women's access to medical education got justified on the grounds that Indian women could not access western medical treatment due to

[1] In ancient India, we find mentions of bed side attendants who cared for the patients and who helped physicians, similar to modern day nurses (Susrutasamhita Book 1, Chapter 34). For details see https://rarebooksocietyofindia.org/book_archive/Sushruta%20Samhita%201.pdf. Last accessed 24.11.22.

the practice of *zenana* (Burton 1996, 373) and it opened the gates for white women to be participating in the medical profession.

The perception that the situation of Indian women was dark and gloomy in India, and they needed to be rescued was used as the justification for colonial rule. 'Single female medical missionaries reworked the script' and argued that if women needed rescuing from zenana, it was to be done by women (Sujani K. Reddy 2015, 8). For female native patients, there can only be female doctors. Thus, protestant medical missionaries started working (following the Charter of 1883 which lifted all bans on the entry of missionaries) in mofussil areas or areas which were neglected by the colonial government and paved the way for future interventions, actions, programmes of the Rockefeller foundation. Using public health and scientific medicines, the foundation became an ally of the Indian nationalist elite, whereby it became a crucial part in healthcare related activities in post-colonial India. Further, by providing access to professional institutions in the metropolis (United States), the International Health Division of the foundation sought to establish a link between post-colonial knowledge and metropolis on one hand, and on the other, a chasm could be created between post-colonial India, and its former coloniser Great Britain. This coming close to USA was thought to benefit it, during the Cold War period (10).

According to Reddy, Rockefeller's intensive work on public health and scientific medicine, led to the development of global biomedical system, setting the standard, defining, framing healthcare and policies and influencing medical professionalization across countries in such a manner that 'its authority persisted through independence movements' (Reddy 2015, 10). The development of nursing profession in India was very much influenced by standards set by American interests. The fact remains that social reforms in India enabled native women to join the profession as well. Kadambini Basu from Bengal and Anandibai Joshi from Maharashtra both graduated in 1886 from Calcutta Medical College and Women's Medical College, Philadelphia, respectively. There is no denying that the health of the native population became a concern of the missionaries, colonial masters, social reformers (and various agencies of imperial forces like United States as S. K. Reddy has argued) and the health of native women became a concern for the suffragists as well (Reddy 2015). Highlighting on the sorry state of the natives, series of articles were published in various nursing journals since the beginning of the twentieth century.

Articles published in the *American Journal of Nursing*, since the first decade of the twentieth century reflected the perception of white nurses in India. As per their documentations, Indians

could not differentiate between a nurse and a doctor and had no idea that food can be contaminated even when not touched by lower caste people. They relied on untrained midwives and healers and expected white female nurses to do almost anything. Untrained midwives was the reason, which explains, why many young mothers died during childbirth, gave birth to dead babies or babies with severed body parts. Native nursing students though were fast learners, with good memory and with affection, but they were "like children", always needing guidance and care. Ultimately strong Christian character was seen to be a prerequisite in making the perfect nurse in a few articles. (Noordyk 1921; Nora Neve 1908; Just 1904; Zenana Bible Medical Mission 1911). Noordyk noted that nursing in India was looked down upon as it entailed doing menial work like "keeping ward and lavatories clean" (Noordyk 1921, 297). The perception of many people regarding nurses, in India has unfortunately not changed with time. It is perhaps in their attempt to establish nursing as a respectable profession not associated with the task of performing menial jobs like cleaning the patients, that a space has been created for another category of women, who are untrained, hailing from less fortunate backgrounds.

Thus, 'a commitment to the imperial mission in India' led to the promoting of medical education of British women (Burton 1996, 373). The works of British women medical practitioners in India and early native women in the same profession are well documented (Burton 1996; Forbes 1994, 516), however, equal importance has not been given to document the emergence of nursing profession in India (Sanyal 2017). In this regard, one also needs to highlight the work of Rosemary Fitzgerald (2006, 185-220) on nursing and the crucial role played by missionaries in setting up the base on which nursing has developed in India. Her work also emphasises the growing self-perception of nurses as agents of empire from the late nineteenth century onwards and their views of India as fertile terrain for their new projects of professionalization.

The Royal Sanitary Commission, appointed in 1859 (in which Florence Nightingale played an important role), in its report highlighted the dearth of nurses for British soldiers, which led to the formation of Indian Nursing Services (INS) as a result of which 10 trained nurses arrived in Bombay in 1888, under the guidance of Catherine Grace Loch. In 1903 INS got renamed as Queen Alexandra Military Nursing Service of India, which eventually got replaced by Queen Alexandra's Imperial Military Nursing Services (Healey 2013, 70-71). Again, in the early days, it was the Protestant missionary nurses had 'monopolised' the business of training native

women and making nurses out of them. The religious linkage was also due to the presence of nursing nuns. Thus, particularly in south India, both the Catholic and Protestant institutions supplied and trained nurses not only to Christian hospitals but also to government hospitals (34). The 'strong association of nursing with Catholic nuns in the early days left a problematic legacy for the state and encouraged migration of Malayali nurses to other states' (Ibid).

Only seven medical missionaries were sent to India in 1858; by 1905, that number had risen to 280. When the number of Protestant medical mission force reached 1,052 doctors and 537 nurses worldwide in 1916, 281 (27%) of the missionary doctors were working in India, while 420 (40%) were working in China. 44 per cent of all missionary nurses worked in these two mission fields: 108 (20%) were in India, and 127 (24%%) were in China. (Fitzgerald 1997, 66). No other mission fields attracted such high proportions of the medical mission force. This work brought to the fore how men hailing from the missions, were salaried and 'engaged in public evangelism,' when women missionaries were unpaid and did the 'ancillary work of domestic evangelism' (67). The stigmatization and low status associated with the profession continued as the nuns imbued with the spirit of service and sacrifice accepted work with poor pay and poor work conditions (35).

## 5.2 Post-independence developments:

In order to ensure standardised quality training and education for nurses, midwives, health visitors and ANMs, the Indian Nursing Council was constituted in 1949, following the recommendation of the Bhore Committee, after the passing of the Indian Nursing Council Act in 1947 (TNAI 2001, 261). Before this, certificates issued by one Registration Council were not recognised in another state. Through this Act, a qualified nurse could get listed in the state registers, provided the qualifying certificate is issued by an examining board recognised by the Indian Nursing Council (INC) and the respective state government (263). However, it needs mentioning that prior to this, there were existing Nursing Acts in several parts of the country like the Bengal Nurses Act (1934), Tamil Nadu Nurses and Mid-wives Act[2] (1926) etc.

Even before independence, the Bengal Nurses Act (1934) had established the Bengal Nursing Council, which was later amended through the Bengal Nurses (West Bengal Amendment) Act,

[22] See https://www.tamilnadunursingcouncil.com/images/1926TNNMC_Act.pdf. Last accessed 04.01.21.

1949. Though it went through subsequent amendments in both 1950 and 1951 respectively[3], it functions under the purview of the state Act, which varies across states (Gill 2016, 516). Following an amendment to the Indian Nursing Council Act in 1957, it became imperative for State Nursing Councils to maintain registers of nurses, who are registered with the respective state councils (TNAI 2001, 262) and later had to renew all the registration certificates after every five years[4]. Further, it is imperative for various State Nursing Councils to secure formal recognition for initiating a new course or programme for qualification that is not listed in the Schedule of the INC Act, 1947 (Nandaraj, Gupta Randhawa 2021,25).

In 1950, Government of India recognised TNAI as a 'service' organization and similar recognition was bestowed upon by the state governments[5], perhaps in order to prevent unionisation of the profession. A few years later, Shetty Committee (1954) was set up to review the conditions of service, including salary, working conditions, etc. of various categories of nurses. It also tried focusing on the organisation of nursing service in India and suggested that there be a Superintendent of Nursing Service in each state, and nursing service in hospitals and public health service be merged into one. It suggested the presence of one nurse (including students) for 3 patients in a hospital and one domiciliary midwife per 100 births. It also suggested providing adequate living accommodation, providing of dearness allowances and allowances for lodging and stay, uniform and laundry, a minimum pay scale for nurses, midwifes and health visitors, and shorter working hours, among other things. Like other previous committees, it also suggested training and improvement of education of all healthcare workers with a focus on nurses, dais and midwifes (TNAI 2006, 183).

It is pertinent to mention that the problems like dearth of healthcare workers, dearth of training institutions etc. have been dealt more exhaustively not in Five-year Plans but by various expert committees. Before independence, the reports of the Bhore Committee (1946) and Sokhey Committee (1948) warrant attention. As per the findings of the Bhore Committee, the education and training imparted in the existing nursing schools were not up to the mark and the existing number of nurses, midwives, *dai*s were inadequate in fulfilling even the short-term goals as forwarded by the committee. Sokhey Committee in its report highlighted the need to train indigenous practitioners like *vaids*, *hakims* and *dai*s (1948, 16), thus giving acceptance to them,

[3] See https://www.wbnc.in/Download_file/download/West-Bengal-Act-XIII-of-1949.pdf. Last accessed 23.04.21.
[4] See https://www.wbnc.in/Main/page/about. Last accessed 24.04.21.
[5] See https://www.tnaionline.org/news/Archive/10.html . Last accessed 02.09.20

something that was avoided by the Bhore Committee (Ruhil 2015, 431). Both the committees had dealt with the socio-economic determinants of health and had focussed on issues like hygiene, nutrition etc. Since around the time of independence, India did not have required number of workers across categories, training and education got emphasised in these committees. However, that there was a greater need for nurses than the doctors, was highlighted by the Bhore Committee (vol. 2, 1946, 348) and urged that majority of the graduating nurses needed to be absorbed in the Public Health Service, the remaining nurses could join services in private institutions including missions (TNAI 2006, 190).

In 1959, the Mudaliar Committee (or Health Survey and Planning Committee) was set up to review how health faired under the two five-year plans. Among other things, it highlighted the non-uniform training standards for nurses, midwives across states, poor standards of accommodation, dearth of healthcare workers which was compensated through the services of nursing students, which in turn affected their studies (GOI 1962, 17)[6]. It endorsed the pay scales as suggested by Shetty Committee and spoke of allowances for stay, uniform etc. (39) Recommending three grades of nurses it stated that a Basic nurse should receive four years of training, including training in midwifery and public health for six months each. An ANM should receive two years of training and should be presented with the opportunity to join basic nursing course. Similarly, there was scope for degree nurse to grow professionally as there was the provision to work as sister nurse after successful completion of three years of service. It also mandated the setting up of a nursing advisory committee in each hospital. Like all previous committees, it too highlighted the need to improve training of healthcare workers and suggested that large maternity hospitals should act as training grounds for nurses, mid-wives, doctors and other paramedical staff involved with child and maternal care (7). However, Mayra, Padmadas and Matthews (2020), in their study revealed how mostly, it is the medical student who gets primacy while practicing in the labour room, while nursing students can at best observe. The Mudaliar Committee even though highlighting the need for male nurses stated that they can be employed for certain work only in mental hospitals, army hospitals, venereal disease clinics etc. (40; 374) thus, reinstating the gender roles that shape nursing as a profession.

The Chadha Committee set up in 1963, was primarily meant for the National Malaria Eradication Programme. It had suggested for giving basic health training to malaria

[6] See https://www.nhp.gov.in/sites/default/files/pdf/Mudalier_Vol.pdf. Last accessed 03.09.20.

surveillance workers and to appoint them as basic health workers. However, when the Chadha Committee's recommendations were put into practice, it was discovered that they were impractical since the basic health workers, due to their numerous responsibilities, were unable to adequately address either family planning or malaria work. Following which, the Mukerji committee was created in 1965 to evaluate the effectiveness of family planning policies. The committee suggested hiring specific personnel for the family planning programme, and endorsed that Auxiliary Nurse Midwives, nurses and others should be paid extra for working overtime in family planning camps (38). It also urged to quicken the training for healthcare workers (52).

Gradually in the 1960s, family planning programme became increasingly important which necessitated de-linking other necessary vertical programme like, maintenance activities of malaria eradication programme, from family planning. In 1966 another committee was set up under the aegis of Mukerji, to enquire into the existing conditions of states with regard to implementation of the family planning programme and other vertical programmes. It sought to review if basic health workers with training could take up more responsibilities of other mass programmes like controlling leprosy, filaria etc. or if it could be integrated into other services. It also spoke of having a Nursing Supervisor at the district level to supervise family planning work and it also highlighted the role of ANMs. Further, Jungalwalla Committee (1967) talked of having a unified cadre, equal pay for equal work, special pay for special work, and abolishing of private practice by government doctors. Integrating services was suggested, as parallel services were treated as wastage. It sought to integrate both preventive and curative services. Dr. C. L Mukherjee, Director of Health Services, Government of West Bengal was a member of the committee and it had highlighted that unification of the cadre of doctors was complete and the scales for doctors in the state along with Punjab, was higher than the rest of the states. Similar emphasis on nurses was absent[7].

In 1973, the Kartar Singh Committee suggested that the peripheral workers should be integrated into a single cadre of multi-purpose workers (both male and female). It highlighted the problem that across India various health programmes were launched at different times implying that all the states were not at par while measuring the progress of a certain programme. It had also suggested that the duration for ANM courses be reduced from 2 years to 18 months and there be a separate category for nurses meant for hospital and community

[7] For details, see, https://www.nhp.gov.in/sites/default/files/pdf/Jungalwal_Committee_Report.pdf. Last accessed 23.11.20.

work[8], thereby diluting the important role that was ascribed to ANMS by the Mudaliar Committee. The Srivastava Committee (1974) urged the government to create a new brand of health auxiliaries who would act as a bridge between doctors at PHCs and multi-purpose workers. Committees under Dr. Bhore, Mudaliar, Shetty along with emphasising on the need to improve training and education of nurses, had highlighted the poor living conditions. However, such an emphasis was lacking in later committees like Mukerji Committee or Kartar Singh Committee which only focused on ANMs and was concerned with increasing their numbers (High Power Committee, 1989,10).

Indian economy hit troubled waters in the seventies, as India had to rely on aid from the western powers, following a drought in mid-sixties that led to an agrarian crisis (Samantaraya and Pattnaik 2006; Kumar 2021). In the same decade, the world saw 134 countries adopting the declaration of 'Health for all by 2020', at Alma Ata Conference of 1978,[9]. This required that that all categories of healthcare workers, including nurses play an important role in achieving this goal. However, the first National Health Policy framed in 1982, with the main aim of setting the path to achieve the goal of 'health for all', did not elaborate on the issue of nurses. Thus, after three decades of independence, a High Power Committee on Nursing and Nursing Profession (hereafter, High Power Committee) in 1987, was set up which submitted its report in 1989. It was argued by the committee that, the 'dichotomous growth of the health services and lopsided development of the nursing profession' (Preface), had necessitated the setting up of the committee. It included reports, proposals and feedbacks from various nursing organisations, nursing councils, government officials, state government representatives and others.

Before any further analysis of the High Power Committee, it is important to establish the context. On one hand, there was this need to fulfil India's commitment to the world of achieving health for all, on the other hand there was the resource constrain. There was a shortage of human resources as well as financial resources. Various expert committees have tried addressing the dual problem with varied emphasis either on doctors or community health workers or allied healthcare workers like pharmacists, laboratory assistants and others. The last category received much attention with regard to their training and education in the Bajaj

[8] For details see https://www.nhp.gov.in/sites/default/files/pdf/Kartar_Singh_Committee_Report.pdf. Last accessed 5.12.19.
[9] For details seehttps://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2. Last accessed 15.05.19.

Committee Report of 1986[10]. Though nurses were mentioned in a scattered manner in a few reports, it was the High Power Committee that was set up primarily for the nurses of various categories during the time of transition. It had tried giving recognition to a profession, which in modern times had become coterminous with women. On the other hand, amidst the importance it had gathered globally, especially with the migration of nurses from India and the importance bestowed by various international forums, this committee expressed the aspirations of certain category of workers who play crucial role in healthcare. It was also set up at a time when the state was gradually withdrawing from various sectors, including healthcare sector.

As per the High Power Committee Report (1989), various nursing organisations had highlighted that nurses were often burdened with non-nursing work of 'peons and *ayah*s' in sub-centres. The problems of poor pay scales, allowances, lack of proper accommodation, disparity across states regarding recruitment, payment, promotion etc. were highlighted. The committee recommended the need for uniform nursing recruiting policies across all states, uniform pay scales and allowances for nurses of similar grade. In a dialogue exchange programme comprising experts from the field of nursing and midwifery across India, TNAI President, Prof. R. K. George, highlighted low pay grades and work overload as two of the main reasons why India experiences high levels of attrition of nurses or migration of nurses[11]. It was underscored by the committee that since no state government employed nursing students during their training period, they should not be made to sign bonds (High Power Committee 1989, 15). As per West Bengal Nursing Personnel (Placement on Trainee Reserve) Rules 2009, Section 5, the above practice is very much continuing in the state of West Bengal[12].

The committee also suggested that minimal standards for fundamental nursing care be established and 40 hours of work each week be fixed as duty hours. The committee further indicated that in order to provide guidance and supervision during evening and night shifts in the hospital, there is a need to increase the number of posts in the supervisory cadre in addition to those requiring education and experience. Majority of the interviewed nurses working in government hospitals confessed that they do not like to work in night shifts. It is not favoured by nurses who are married and have young kids, or who have got older parents/in-laws. On top of it, in the event of a patient's death or deteriorating condition, they would be the ones facing

[10] See https://www.nhp.gov.in/sites/default/files/pdf/Bajaj_Committee_report.pdf. Last accessed 3.8.21.
[11] Online panel discussion on 'Have we learnt our lessons from the pandemic – is India's nursing infrastructure ready for a next wave?', held on December 10, 2021. It was organised by Think Change Forum.
[12] See https://www.wbhealth.gov.in/uploaded_files/notice/hng417.pdf. Last accessed 23.4.19.

the wrath of the patient's family. 'Though junior doctors are present, we have to bear everything'. *Transfer casegulo o raat e prochur ashe, shegulo samlate hoy* ('The referred patients also arrive in great number, during the night and we have to handle it all'), said a staff nurse, working at a medical college and hospital in Kolkata, before joining her shift[13].

The High Power Committee also wanted to improve the status of the nursing profession. It recommended Gazetted rank for nurses working as ward sister, giving district public health nurses and district medical health officers equal status, involving nursing personnel in the planning process, while dealing with hospital requirements. The Nursing Superintendents should have a fund at their disposal for buying supplies and equipment during emergency. It recommended making arrangements for apartment like living arrangements for nurses who are not from the place of work, so that they can live with their families. About Auxiliary nurse midwives and female health workers working at the community level, it was recommended by the High Power Committee that they be trained for six months in the health supervisor course and be appointed as health supervisor (female).

## 5.3 1990s onwards:

It needs to be reiterated that private healthcare services or private practice has existed for a long time in India, however what was new since the liberalisation of the economy, was the phenomenon of increasing commercialisation and corporatisation of healthcare (Baru 2006, 3). Liberalisation of the Indian economy implied that the state would reduce expenditure in all sectors including health (Basu 2016, 2; Ray 2019, 77) which had serious ramifications for the service providers as well, since bulk of the allocated money (under any budget) is spent on salaries of various categories of government employees (Basu 2016,3). When overall government spending reduced substantially, it became obvious that the government could no longer maintain the huge workforce or continue financing various institutions as it did earlier. In order to make institutions self-sufficient, user fees were introduced in government hospitals. Direct recruitment got replaced by casualization of workers, mainly paramedical and Group D staff, and hiring private sector doctors on contractual basis also became a practice (Bisht and Menon 2021, 42).

[13] Personal interview on 18.9.19, 5-5:45 pm, Kolkata.

Around this time, a Working Group on Nursing Education and Manpower in 1991 (Nair 2012) was constituted which suggested changes that could not be fully realised almost after two decades of its formation. It had suggested that the GNM programme would be phased out by 2020, and B.Sc. nursing curriculum would be modified and made at par with the international standards. It also encouraged nurses to undertake research related activities like doing MPhil or PhD. When it came to staffing patterns, norms set by Indian Nursing Council had to be adhered. Suggestions were provided as to how the status of nursing profession in India and Indian Nursing Council could be improved[14].

1991 onwards in West Bengal, there has been a change in hiring practices for both healthcare and support workers like sweepers, general duty attendants, cooks and others in government hospitals. In order to compensate for the shortage of doctors, nurses, technicians and others, hospitals hired temporary personnel on contract basis (Roy 2010,143). For the contractual employees, the state has a human resources development (HRD) division. The HRD cell oversees state level recruitments. Group A and B employees are hired at the state level, whereas Group C and D employees are hired at the district level by the District Health and Family Welfare Samiti, which is run by the District Magistrate. Nurses are hired at the state level and in order to overcome the shortage of ANM nurses in rural areas, the state has created the post of Second ANM, which is a contractual position. Under the Public Private Partnership (PPP) model, the state has employed private NGOs in this situation, which serves as a training facility for the ANMs and deploys them in or near areas from where they hail (MoHFW 2013, 9). The subcentres visited during field work in the districts of Jalpaiguri and Alipurduar respectively, had Second ANMs in charge of daily activities including supervising the work of ASHA workers, the position of First ANM lay vacant for years. Despite repeated written requests, no new posting could be arranged. What also became evident is the difference of payment, as illustrated below (MoHFW 2013,12).

*Table 1*: Pay pattern of contractual and regular nurses

| **Category of Workers** | **Contractual *** | **Regular** |
|---|---|---|
| Staff Nurses | 17000 | 22000 |
| ANMs | 9300 | 15000 |

*(community workers were paid from NRHM fund) Data as of 2013.

[14] See https://www.nursingpath.in/2013/04/development-of-nursing-education-in.html. Last accessed 12.12.21.

West Bengal Government has increased the age of retirement for nurses working in government hospitals from 60 to 65 years and the age limit for joining nursing services on contractual basis has also been increased from 39 to 45 years [15]. All these acts can be perceived as efforts made by the government to save money, by hiring less people in regular/full-time positions, as recruiting full-time/ regular staff would otherwise entail, paying high salaries, other benefits like house rent allowance, provident fund etc., which would increase financial burden of the state (Roy 2010,415).

Despite the above trends, West Bengal happens to be one of the very few states where the majority of patients still receive inpatient care in government hospitals, while at the national level, the private sector's share of the inpatient care market has increased considerably (Kanjilal 2007,16). 'The rush is towards various medical college and hospitals which act as tertiary referral hospitals, located in important towns of the state. But ultimately critical cases from those hospitals also get referred to Kolkata hospitals depending on the specialisation required. In addition, Kolkata hospitals have to accommodate people from in and around the city, which greatly increases the daily burden on these hospitals'[16]. Though private hospitals are supposed to provide healthcare services to the poor by reserving 20-40 percent of beds or providing free or subsidised outpatient services, to what extent that is followed is debatable. Thus, it is mostly the poor or lower middle-class people who avail the services of the public hospital, and the upper and middle class opting for private healthcare service is the "norm" (Saha and Daw 2016, 402). Similar observation was made by Donner (2017), when in her study she noticed an increase in caesarean deliveries and noticed that it is a mark of status symbol for middle and upper-middle class families. Thus, when the middle and upper-middle class opted for more personalised care which was offered by the private sector, the public sector was left with clients who could not afford the 'personalised care' that was offered by the private sector (Bagchi 2023, 102). Based on interviews with both the providers and receivers of care, it can be said that the perception of the service seekers or clients as hailing from 'low-class', have inadvertently created a hierarchy between the service providers (careworkers) and service seekers/clients (care receivers) that affects the nature and manner in which healthcare as a service is provided in government institutions. Though nurses might have other identities along caste, class and religious lines, those have been outside the remit of the present study.

[15] See https://medicaldialogues.in/wb-govt-raises-retirement-age-of-nurses-to-62-years. Last accessed 3.11.21.
[16] Interview with Deputy Nursing Superintendent, in a Medical College and hospital, located in Kolkata on 23.09.16.

## 5.4 *Ora/Aamra* (Them/Us):

On a summer afternoon, when I visited a Primary Health Centre in *Purba Bardhaman* district (of West Bengal), the ward to which access was granted was almost full. All of them were women and their family members were fanning them, since the fans in the ward were not functioning properly due to voltage problem. There were no attendants/ *ayah*s in the ward. The patients hailing from poor economic backgrounds could not afford hiring anyone for any extra help, I was told. The family members rested on the mats spread between beds. Most of these women admitted, either had or were going to deliver babies. Right outside the ward, one middle aged man with neurological problems lay on his wife's lap in the corridor, while his wife requested the doctors to attend. There was no vacant bed for him and there was lack of facilities to treat him as he kept on having continuous seizures. One of the ambulance drivers present stated, '*Eshob transfer case… ekhane hat i debena*' (These cases normally get transferred (to district hospital and then to any medical college and hospital) as nobody will take responsibility of such a critical patient). Though male patients were present, they were present to avail OPD services only, on the day of my visit[17].

Gopa Mallick, the staff nurse, who had agreed for the interview, was in charge of preparing patients for the operation theatre (OT)/labour room and reported that her job was also to accompany them inside. The interview commenced in the area, right outside the OT. While one patient was already inside, a pregnant woman lay on a trolley, outside the OT, for her turn to come. As the interview proceeded, the woman in the trolley started expressing her discomfort due to pain. At one point, the nurse snubbed the patient and said, "*Joto nekami! Toder to tor sohe na, ekhon bojh"* ('Do not pretend ignorance! You people [looking down on the patient's socio-economic background] cannot control your urges, so its time you face consequences'). Her rebuking the patient continued, despite the latter's plea to administer drugs for pain relief. Though prenatal or antenatal care was provided at the respective PHC, focus was also given to family planning. However, Gopa had expressed her doubts as to what extent awareness programmes regarding family planning could be considered successful, given that teenagers (under 18 young women) were availing services for institutional deliveries [18].

[17] Based on field visit and interaction with support staff at PHC (Purba Bardhaman district) on 04.04.19
[18] Interview with Staff nurse at PHC (Purba Bardhaman) on 04.04.19.

Another time, I was accompanied by an *ayah mashi* ('mashi' means aunt in Bengali, however, it is often used to address the domestic helps and *ayahs*) Mallika Kundu, to the maternity ward of a premier government medical colleges and hospital in Kolkata. She took me to a patient who had given birth a night ago. Originally from Magadha region in Bihar, she was living in Uttarpara with her in-laws. She was related to one of the Group D staff, which made it possible for her to secure a bed, last minute. Mallika took me to her, as she knew of the harrowing tale, the patient was to share. She was in tremendous pain, and her blood pressure had dipped and she had fainted. When she regained consciousness, the nurse who was present had hurled abuses in front of a male junior doctor, shamed her for getting pregnant so young. The patient had become hysterical and fainted again. Later, a C section operation had to be performed to relieve her of the pain[19]. It was not known that her embryo had developed amniotic band syndrome (when strands of amniotic sac, entangles part of the foetus) as no ultrasound sonography was performed closer to the delivery date, either by her family, or the institution where she was admitted.

Kohinoor Nehar, a senior nurse associated with the department of gynaecology and obstetrics, in a Medical College and Hospital located in Kolkata pointed out that women with simple as well as complicated cases come to the tertiary hospitals, which increases workload. She was of the opinion that just as institutional deliveries have been to a large extent normalised in the state, where women (who have no birth- related complications) are giving birth in PHCs or Rural Hospitals, provisions for ultrasound scans and technicians in order to prevent complexities due to abnormality in foetus, should be really present in all PHCs and RHs. 'Ideally when patients come for medical termination of pregnancies, owing to complications, we cannot properly do a follow-up, because of the long waiting list', she stated. "*Oneker shorir e kichhu thake na, har ber kora, onek shomoy mone hoy ei dhokol nite parbe toh. Kichhu shomoy daktar ra iron tablet er free sample gulo diye deye ar ami boli boyish kom haal na chharte. Meye-bouder pechhone artha byay onekei baje khoroch bole mone kore toh. Ekjoner khub risk chhilo, kintu she bacha noshto korbena, Iswarer kripay phutphute ekta meye holo, ekhon dujon e shustho. Patient er baba pa joriye daktar er amader kadlo…ei byapar gulo eto odhbhut lage na"* ('Many patients who come are so skinny, that I fear if they would be able to go through the process of medical termination of pregnancy. At times doctors give them iron tablets for free that they get from medical representatives as spending on health or treatment for girls and women is considered to be a waste of money, while I tell them not to lose hope as

[19] Interview with Nitu Kumari on 01. 09.17, in Kolkata.

they are all young. One patient declined terminating her pregnancy, despite it being high-risk. When she gave birth to a little daughter, her father fell to the feet of the doctor and nurses in gratitude. There is no word to express how it felt like')[20], she added.

Similar experience involving an expression of gratitude was shared by Salma Chowdhury[21], a nurse working at a PHC near a *diar* or *char* in Jalangi, sub-division, Murshidabad district. It was late into the night when she received a patient, who was a resident of *Char Parashpur*. She had developed labour pain after dusk, when movement gets restricted in *charlands*. Negotiations with on duty BSF security guards and then crossing the river Padma, further delayed her admission to the hospital. She reached the hospital after four hours and was completely senseless. The nurse remained with her throughout the night and had also counselled her family members. When her son was born and she was being discharged, her family and people from the char had come with a hen as a gift for the nurse. "*Kichujon dunombori kaj er songe joriye pore, kintu emni manushgulo khub shadamata, bhalo. Shei murgi dekhe hospital e shobar ki hashi, ami kichhutei bujhiye parina, je murgi amar lagbena*" ('Though some residents of these chars get associated with smuggling, but in general people are simple and nice. When people in the hospital saw that hen, they laughed at me, and I could not make the family understand that I did not need the hen'). These acts of gratitude, enhances their self-worth and gives them job satisfaction. These 'intrinsic' rewards often compensate for low salaries, long work hours, huge workload etc. (Morgan, Dill, Kalleberg 2013; Garner et al. 2015; Ayalew et. al. 2019). Salma had stated that in remote areas, where doctors are not present every day, the least nurses can do is be present, otherwise in her words, "Ei manushgulor songe toh onyay hobe." ('it would be unjust for people in remote areas.')

While many healthcare workers (doctors and nurses primarily) in government hospitals were found to be addressing the patients as *tui* (normally used to refer to someone younger – in this case it implies looking down upon), however, that cannot be construed as lack of care. Albeit it highlights the socio-economic and cultural gap that exists between the careworkers and receivers or patients, the gap which is acknowledged by both the parties involved. Empathetically speaking about the poor clientele she had to handle on a daily basis, Srimati Sarkar, a nurse working in the Medical College and Hospital in Bankura district, had firmly stated that she did not pass her B.Sc. Nursing and subsequent diploma, for providing bed

[20] Personal interview conducted on 17.7.17 in Kolkata.
[21] Personal Interview conducted on 08.09.16 in Murshidabad and telephonic interview on 16.01.21.

pans or sponge baths to the patients. When asked about the presence of *ayahs*, she had stated that most of the patients coming to the hospital she is associated with are so poor, that they cannot hire the services of *ayahs*, a practice which is a regular feature in the government hospitals of Kolkata, Burdwan, Siliguri. The few *ayah*s present are found in maternity wards. In other (non-critical) wards, family members do the cleaning work[22].

Similar argument was made by Tina Saha, working as a sister-in charge in a Medical College located in north Bengal[23]. She had highlighted that the extent of contact with a patient's body is limited to measuring body temperature, pressure, sugar level, administrating an injection, making channels for blood transfusion and so forth. For all other activities involving 'touch' or contact with the patient, the preference is towards relegating those tasks to general duty assistants, *ayahs* or other orderlies. During their training, nurses learn how to blend their intellectual, analytical side with their emotional, caring side. Nursing touch is an art, a disciplined act governed by procedures. Additionally, it is a private, sensitive, and human act in which both actors—the person touching, and the person being touched—are subjects. As nurses increasingly delegate the 'body work' of nursing to 'aides', it has become necessary to employ careworkers like *ayahs* in institutional settings (Van Dongen and Elema 2001, 150). Nursing aides like *ayahs,* are not educated in the art of touching but in the technical aspects of body care (149-151). Though it is the duty of the nurse to provide care to the patients, they do not want to care through much touching or bodily contacts especially involving any contact with their body fluids. This sentiment has been echoed by all the nurses interviewed in government institutions.

While cleaning body fluids is mostly unacceptable to the nurses, cleaning of various equipment or tools required in the operation theatre is considered to be acceptable. Dressing wounds, removing blood from various operating tools, sterilising them are all part of activities that a senior OT nurse is expected to do. *Egulo technical byapar* (These are technical issues), Sikha Sikdar, a senior OT nurse associated with a Medical College and Hospital in one of the districts in north Bengal, pointed out[24]. 'How much chemical disinfectant to use or which sterilisation process needs to be adopted, depend on the nature of tools or equipment. For this, one needs to have proper knowledge of Chemistry. Unless the operation theatres are properly sanitised there

[22] Personal interview conducted on 20.03.21, in Kolkata at the interviewee's residence.
[23] Personal Interview with Sister in Charge of a state medical college and hospital in north Bengal on 14.08.2022.
[24] Personal Interview with a Senior OT nurse in north Bengal on 14.08.22.

always remains chances of contamination, hence only people with the right knowledge are allowed to do so', she added.

First two instances mentioned above might lead one to question as to how such people can be referred to as caregivers or their acts related to the idea of care. Noddings (2013) bluntly accepts the fact that it is not possible to 'care-for' (involving direct attention and response between the one caring [in this case nurse] and the one cared for [patient]) everyone, as there is paucity of time and resources. However, what big organisations can try is to nurture an environment where 'caring for' might develop with time. Further, that nurses in government facilities, despite their huge workload and albeit foul mood, temper, continue providing care to the next patient in need of it and never abandon her, might prove that though caring is intrinsic to care ethics, but as an activity carework can be carried out with or without caring (Preface). Or it might lead us to approach 'care' and 'nursing' differently. However, Noddings' idea of caring is narrowly framed around mothering and thus, has been subject to lot of criticism (Dalmiya 2016, 66). It might also be true that there is a certain amount of unevenness (or inequalities) associated with caring as it leads to dependencies on the part of the old, sick, infants, which do not however lead to any form of oppression or exploitation (15).

Search for dignity had landed Pramila Roy on the job of a GNM nurse associated with the Rashtriya Bal Swasthya karyakram (School Health Programme) in Basanti block in South 24 Parganas. She was employed on a contractual basis and earned a meagre amount[25]. She had to stay by her ailing mother and could not leave her for working in hospitals located far away from Canning, her place of residence. She did not want to sit idle, (*bekar,* as she had put it) hence accepted this job. Later, when her mother's condition improved, she had applied for a position under West Bengal Nursing Services and had joined the district hospital in North 24 Parganas. Though there was uncertainty associated with the contractual nature of her job, however, that she worked on a government project earned her respect in her locality.

Pramila's job was to collect non-invasive quantitative measurements of the student's body like her body weight, her height, pulse rate, blood pressure etc. and prepare notes about patient's histories during the screening of kids at Anganwadi Centres and schools. She was also involved in micro-planning, daily, weekly, and monthly record keeping, and reporting. Interestingly, I

[25] Though she did not disclose the exact amount, a look into https://pmposhan.education.gov.in/Files/School%20Health%20Programme/Guidelines_SHP_29TH_JAN_09-FINAL_FINAL.pdf, pertaining to School Health Programme, would give us an idea; interview conducted in a district hospital in North 24 Parganas district on 23.07.16.

got the reference of Pramila from an *ayah*, working in the same institution, whom I had interviewed. Moyna Mondal, the *ayah*, was close to the president of the union for contractual workers and the president in turn was close to Pramila. When I had informed her of the source from where I got her reference, she warmly acknowledged that she had high regards for the president of the above union. It was later that she had informed me about her starting her career as a contractual worker. 'Whatever one might tell, the truth is one has to work doubly hard if one is working on a contractual basis. Be it pleasing the immediate bosses or local political leaders, extra effort is a must, as there is always a lurking fear that the contract might not get renewed and people take advantage of that fear. Amidst such uncertainty, respect and collegiality are little things that one can offer', she had added. Later during my interview with Moyna Mondal, she had stated that very few nurses address contractual workers or careworkers like herself as *apni* (used to address someone senior or elder; it implies respect), but Pramila is unlike others.

Most of the respondents had acknowledged that they have faced gender-based harassment in their work places. They have been abused and compared to prostitutes by patients' families since they work together with male colleagues, or touch male patients. Krishna Pal[26], a senior OT nurse had explained that normally people come to government hospitals, when the private institutions can no longer help and the families cannot bear the huge bill amount charged by those institutions. Many times, patients are brought in dead at night. But in order to avoid getting beaten up, we still give oxygen to the patient, show the families that we are administering injections, a junior doctor would also come to check and much later, we inform, the families that the patients have expired. Not only have patients' families, but even doctors also ill-treated them. Narrating a similar incidence when a patient was brought in dead, Krishna said that when she went to call a junior doctor who was present on the night shift, he had screamed, "*Mere chamra gutiye debo*" ('I will beat you and skin you up'), because he was woken up from his sleep.

[26] Telephonic interview conducted on 24.09.20.

## 5.5 In Search of Dignity: The Case of Contractual Nurses in Rural Areas of West Bengal:

Punam Rai working as a second ANM in a sub-centre, adjacent to Beech Tea Estate in Alipurduar district in north Bengal, had expressed frustration stemming from lack of certainty as pointed out in the previous paragraph. Since her posting, no other ANM nurse (regular) was posted in this centre. From delivering child and maternal care to overseeing work of ASHA workers allocated to the respective sub-centre, helping them fill up detailed reports after their house-to-house visits, organising village health and nutrition day and organising field visits with them at least once a month are some of the many tasks that she needs to undertake. She also needs to verify the reports submitted by the ASHA workers and every Wednesday needs to have a mentoring session with them. On the third Saturdays, she needs to sensitise the ASHA workers on any new guidelines or changes in the guidelines pertaining to the community health work as per the National Health Mission or NHM (in 2013 National Rural Health Mission and National Urban Health Mission were merged to launch NHM[27]).

Since the writing of this thesis overlapped with the on-going pandemic, it was imperative to briefly state the experiences of careworkers during that period as well. For instance, the ANMs along with ASHA workers had to carry out vaccination drives. During the COVID-19 'lockdown', when huge numbers of migrant workers from all over the country were returning to their homes, ASHA workers had to collect samples, monitor asymptomatic patients who were sent home and were living in isolation. ASHA workers were the first point of contact with the state healthcare system, had to be available almost round the clock and in return they had to face stigma in their localities. Since they had to check up on COVID infected patients, they were seen as the 'carriers of the viruses'. During the pandemic child and maternal care took a backseat as the priority was containing the spread of the virus (Ahamed and Basu 2021).

Sakina Bibi, working as ANM II at a sub-centre near Chamurchi Tea Estate, in Jalpaiguri district, narrated how presence of mind had saved her and her co-workers from getting beaten up during the pandemic. When after prior announcement for vaccination, vials did not arrive till 3 in the afternoon, and people were waiting since the morning, there was so much anger that there was every possibility of an assault. When repeated pleas for guidance to her superiors did not work out, she had to take the decision of administering distilled water in syringes to pacify the mob. They were asked to return on another date to get proper vaccines. 'No manual,

[27] See https://www.nhp/gov.in/national-health-mission_pg . Last accessed 13.09.21.

no guidelines tell you how to react in a situation like this. If anything, untoward was to happen, then we were going to be used as scapegoats. ASHA *didis* are only volunteers despite their hard work and we are contractual workers, who are looked down on by other nurses working at the government hospitals,' she argued[28].

Apart from ANMs or GNM nurses working in government health centres in rural areas, various trusts, missions, NGOs, factories, tea estates and so on also provide healthcare. During field work, I had come across healthcare centres run by the management of tea gardens in collaboration with some trust or NGOs. Management approved nurses working in those centres were also interviewed. All the interviewed women working in centres associated with tea gardens in the districts of Jalpaiguri and Alipurduar reported completing their training from private institutions located in Siliguri city, a cosmopolitan business centre in the Darjeeling district. However, due to family compulsions or loyalty towards the management, these women could not go elsewhere for work. For instance,

Not only uncertainty due to the contractual nature of employment, nurses in tea gardens also faces uncertainty when tea gardens shut down. For instance, when Kristi Toppo, a management approved nurse, had first joined the centre in a tea garden in Birpara area of Jalpaiguri district, there were regular doctors associated with centre, there were other staff members and a fully functioning operation centre. Her specialised training as an OT nurse (after doing her ANM course) had come in handy. Operations involving removal of hernia or appendix could be done (for other complicated cases, they had to go to either Malda or Siliguri)[29]. The garden Kristi is associated with closed down in 2015. It resumed work after 19 months to be shut down again. It reopened in February 2021. Due to familial compulsions, Kristi continued working in the tea garden even after a salary cut. Mary Gond and Rima Rai associated with centres in Red Bank and Surendranagar area had stated that from 2013-2022, the two estates where their centres are located were shut down. It resumed work since August 2022. While these gardens were closed NGOs like Manbhum Ananda Ashram Nityananda Trust (MANT), Sobuj Sangha (Alipurduar) sent doctors once or twice a week along with laboratory technicians and others. Though the labourers sold harvested tea in the market and parts of machines used in factory to sustain them, the nurses had to visit centres and yet received a paltry sum of money. "*Agar humlog Siliguri mein hote, toh kahi na kahi accha naukri mil jata, par haya toh kuchh nahi hai"* ('If we were

[28] Interview conducted in Chamurchi, Jalpaiguri District, a northern district of West Bengal on 17.08.22.
[29] Interview conducted in Birpara, Jalpaiguri District on 17.08.22 and 18.08.22.

in Siliguri, we would have found decent work there, but here [implying the interior parts of Jalpaiguri] there is dearth of opportunities for employment') (Ibid).

The nurses associated with tea gardens, hope that soon a government sub-centre or a primary health centre would be established in the tea gardens and they would all be absorbed in it. Working in the government sector would increase their *ijjat* or respect in society, they believe. Having professional degrees from private nursing training centres, these nurses provide first aid care, medicines for common illness like fever, common cold etc. Though ANM nurses and ASHA workers from government centres visit these areas on specific days every month, it is them who look after the daily health of the residents of the tea gardens (comprising workers of various categories) and report on a weekly basis to the tea garden manager (Ibid).

Be it the ANM II nurses or the management approved nurses discussed above, all of these women belonged to the age group of 35-45 years. In the absence of other co-workers like ANM I or doctors on a daily basis, these women have to do a lot of work and get half remuneration earmarked for a regular nurse appointed by a government. They had argued that such differential pay structures presume that all women would be married or would have other earning male members in their families. Government often forget that single/ widowed/ divorced women are most of the times the only earning member of their families. Unless the problem of pay parity is fixed, the idea of respect would be ever elusive for them.

## 5.6 The Search for Dignity Continues: Nurses in the Private Sector:

Though this section deals with nurses working in the private sector, the focus is on nurses working in cities, towns and **not** interior parts of West Bengal (which has been done briefly in the previous section). Though West Bengal has had a private healthcare sector since colonial times, big private hospitals like Woodlands (1947; initially named the East India Clinic), Belle Vue (1967), Calcutta Medical Research Institute (1969) came up in sixties (Basu 2018) and cohabited with numerous small nursing homes run by senior doctors offering personalised care receiving patronage from the relatively wealthy sections of society (Qadeer, Arathi and Saxena 2021, 27; Bagchi 2023). Post-liberalisation healthcare in India as well as West Bengal is characterised by healthcare acquiring 'industrial proportions', while earlier private health sector operated at a small level where a doctor's wife might have overseen the cooking of patients' meals (Bagchi 2011,1226), thus moving away from the heterogeneous nature that dominated private healthcare sector in India (Qadeer, Arathi and Saxena 2021). With the onset of the new millennium, the healthcare sector in West Bengal has seen a rise in private

investment with hospitals expanding their bed capacity, establishing branches throughout the city, and investigating alternative revenue models.

There has been a growth in the demand for qualified nurses in India as a result of the expansion of urban areas, the middle-class and the rise of what is frequently referred to as "medical tourism". As a result, like in several parts of India, West Bengal is also witnessing a constant flow of nurses from different states (Basu 2018, 112). Moreover, compared to other Indian metropolises, the cost of medical care is lower in West Bengal (Ghosh 2012). Again, the fall of the value of rupees against foreign currencies and tie-ups of various hospital chains with airlines and hotels in order to provide subsidised rates to patients seeking healthcare services in India, have also facilitated medical tourism (TOI, September 13, 2013). For instance, the Apollo Gleneagles in Kolkata had agreements with GMG Airlines, a private airline from Bangladesh, and with several big private hotels to provide cheaper plane fares and lower lodging rates for medical tourists (Ghosh 2012).

Another reason for the constant flow of nurses could be traced to an increase in nursing training institutions. Though at the beginning of the new millennium, south Indian states were leading, however, between 2004 and 2010, the concentration of nursing institutions in the southern states of India has seen a decline. The overall number of institutions offering B.Sc. nursing programmes increased six times (with noticeable increase in Madhya Pradesh, Maharashtra, Punjab, and Rajasthan) and the number of institutions offering General Nursing and Midwifery (GNM) diploma programmes had increased three times during the same time period (Basu 2018,112). The situation has slightly altered between the beginning and the end of this research endeavour. An interview at a private hospital in 2015 on the Eastern Metropolitan Bypass revealed that out of 1,200 nurses, 65 per cent have come from outside West Bengal. The majority come from Kerala, followed by those from Andhra Pradesh, Odisha, Jharkhand and Manipur. Though the above trend of nurses migrating to Kolkata continues, however, by the end of the research Manipur seems to have come up as a major source providing nurses in many private hospitals of the city.

Following liberalisation of the Indian economy, multiple private hospitals and super speciality hospitals had come up first in Kolkata and then, started to spread in other major cities in the state like Durgapur, Midnapore, Siliguri and so forth. Private hospitals (for profit ones) are guided by profit motive and have increasingly shifted towards hiring careworkers on

contractual basis. At times hospitals sign contracts with placement agencies, and it is these agencies that pay the nurses their salaries. On asking, one of the managers of such placement agency had stated that the nurses are paid according to the government norms, by which they imply adherence to minimum wage rate for skilled workers like nurses. As per this, the skilled nurses would be getting something around Rs 11,000 (according to minimum wage rate) and the agency pays them 15,000-18000 depending on their experience[30], while staff nurses in government sector get around Rs 35,000 in their early days of career[31]. The harsh reality of pay disparity becomes obvious.

Approximately forty per cent of the 180 to 200 nurses working in a south Kolkata hospital owned by a trust come from outside the state, revealed Uma N. Kutty, native of Kerala[32]. Twenty nurses had recently joined the hospital after completion of their the GNM course from Kerala. Apart from Malayali nurses, the remaining nurses are from Manipur and Odisha. Be it Uma or Anu from Kerala or Bijoya Devi from Manipur, nurses working in private hospitals stay either in hostels or other accommodations provided by the hospitals or rent places near their places of work. In the latter case, in some instances, part of the rent is included in their salary. Nurses hailing from a particular region tend to stick together. Living together in groups prove to be easier. From doing groceries, to cooking or cleaning they divide their work. As they all have to send home part of their salary every month, 'it is economic to run a household together, than run it by oneself', opined Anu[33].

Since the migrant nurses are not residents of West Bengal, they cannot avail subsidised materials from ration stores. "*Kam daam me chini, geu sabko milta hain, par humko bahar se lena parta hai. Bohut time ekdin ka sirf cabin cost, humare salary se zyada hota hain*". ('Everybody from this state can avail sugar or wheat grains from fair price stores, at subsidised rates, but since we are not from this state, we have to buy those essential items from the market, at a higher price. Most of the times, the money hospitals charge patients for just one day's stay in some fancy cabin, is more than my salary'). 'We too need foodgrains at subsidised rates to sustain ourselves', said Bijoya[34]. While in government hospitals, nurses work for 8 hours, in

[30] Interview with Nagen Nandy in Kolkata on 07.08.21.
[31] See https://stateinfos.com/salary-of-west-bengal-govt-staff-nurse/. Last accessed 13.12.21.
[32] Interviewed on 26.08.19, Kolkata.
[33] Based on telephonic interview, held on 09.09.21.
[34] Interviewed on 26.08.19, Kolkata.

private sector, on many occasions they end up working for more than 12 hours. Interviewed nurses reported that they were overburdened and underpaid and hence treated with less respect. 'We are made to feel that we can all be easily replaceable', said Kimpi.

In a different city, or state, fellow nurses from one's home state act as a support system. For instance, nurses from Mizoram and Manipur are constantly in touch with others from their respective states over WhatsApp, Telegram and so on. 'During a crisis, I know my brothers and sisters would come to my aid', stated Kimpi Moitei from Lunglei, Mizoram. Her assertion proved to be true during the pandemic. When nurses from north-east India faced racial profiling and stigmatization, various organisations of their respective states and their state governments came to their rescue [35].

## 5.7 The heterogeneous private sector:

As mentioned earlier, heterogeneity in the private health sector declined gradually with the onset of liberalisation, however, that is true for urban centres only. Smaller towns or cities away from Kolkata have still managed to retain somewhat heterogeneity. During my field visit, I have come across private nursing homes run by owners of rice mills, cold storage, other businessmen, senior MBBS doctors, and trusts. These centres often make headlines after conducting botched surgeries, illegal abortions, selling new-born babies (TOI July 11,2002; TOI November 25, 2016) and other irregular activities (*The Telegraph*, February 26, 2017). Yet, due to overcrowding of government hospitals, or due to private practices of government doctors or the presence of a nexus between staff of government facilities and owners of these private nursing homes, a huge section of the population, away from Kolkata, end up seeking services in such facilities. Only five nurses out of eight such facilities, said that they were registered with WBNC. The others were merely nursing aides, carrying on the jobs of a registered nurse.

During a visit to a nursing facility (mainly a maternity home) in north-central Kolkata, it was discovered that women from the Sunderbans, Bongaon, and other areas migrate to work as nurse's assistants. Though registered ANM nurses were present in the respective centre, for operations, "special nurses" working in government hospitals were hired for the day, informed

[35] Interviewed on 20.08.19, Kolkata and over telephone on 22.03.22.

a male staff[36] who is in charge of doing multiple duties like fetching stretchers, delivering letters, overseeing plumbing and wiring etc. During my field work, I have not come across any nurse from outside West Bengal working in the above type of private nursing facilities. A bare minimum pay of Rs 5000, will not be enough for nurses coming to work in West Bengal.

With the decline in agricultural productivity in the district, women have been forced to work round the clock for very low wages and have been forced to work in whatever job roles that seem to be available. Poornima Das, a middle-aged woman, working as a nurse, with no nursing degree, who is a resident of Mangalkot, near Burdwan, stated that after her family sold their family land due to crop failure, this was the most respectable job that she could have found herself. She was informally trained and other staff members present during the interview stated that she was 'as good as a nurse'[37]. Most of these facilities deal with maternity cases primarily, since the perception is that C section delivery is safer mode of giving birth (Ibid).

During the field work, I also found that most of the private nursing homes or hospitals in mofussil towns or small cities have flourished along the state and national highways and in close proximity to state hospitals or medical college and hospitals in district towns. Imanul Haq, a doctor associated with a private hospital in Kaliachak, Malda had explained that private hospitals are positioned in the above manner to ensure three things: first, to ensure that whoever does not find place in the targeted government facility ends up in the private facilities around it; second, to ensure faster movement of patients. Most of the small cities are crowded inside and the only areas where movement takes place without much obstruction are areas along the highways. Thirdly, private hospitals try to ensure that government doctors are also associated with their facilities. This would mean that doctors would refer some of their patients to the facilities and the management will also be able to draw more patients, by showcasing the association of government doctors. [38]

Nurses working in such private nursing homes and hospitals are usually from around the locality. Even when some of them have migrated, they have migrated because of marriage and not for work. They are also recruited by the management based on recommendations from familiar sources. Nurses from similar social backgrounds are given primacy while getting

[36] Interviewed on 24.08.2016.
[37] Interviewed on 15.07.2018 in Burdwan town.
[38] Telephonic Interview held on 06.10.21.

employment. For instance, a Bengali speaking owner might not prefer a Hindi speaking nurse in a small town like Domkol, Murshidabad. However, language would not be an issue in bigger towns like Berhampur in Murshidabad.[39] Perhaps as one moves towards a bigger city, all traces of cultural differences take a backseat, while giving employment.

## 5.8 The Reality of Nurses' Migration:

Since 1970s, nurses from Kerala, especially Kerala Christian nurses, had emerged as "the" category of nurses migrating out of India, definitely in United States and also in other countries and they continue to 'dominate Indian diasporic imaginaries' (Reddy 2015, 15). Predicting a possible shortage of nurses in USA, an emphasis was given on recruiting internationally educated nurses (IENs) for both hospitals and nursing homes in America (Buchan and Sochalski 2004), through hundreds of international nurse recruitment agencies located in regions of Africa and Latin America where there is a severe scarcity of healthcare workers as well as healthcare resources (Gostin 2008). Other popular destinations for Indian nurses are the Gulf countries, Singapore, Malaysia, UK, Malta, Germany, Ireland (Tsujita 2018; Chandna 2021). Respondents of this research also indicated that Australia and New Zealand are popular among young nurses as, 'the scope is huge and the region relatively less explored'.[40]

While India is a major exporter of nurses to various countries in the world, it suffers from a severe scarcity of nurses as well. T. Dileep Kumar, president of India Nursing Council had stated that India would need 4.3 million more nurses, to meet WHO's norm in 2024. This would require, creation of new posts both education and job sector. President of Trained Nurses Association of India, Roy K George, has recently highlighted shortage of decent positions with decent pays in India, which forces nurses to migrate (*Business Standard*, September 2, 2021). During field work respondents had reported that for pursuing a GNM course in a private college the cost would be something between Rs. 2 lakhs to 5 lakhs, while for B.Sc. course it would be between Rs. 8lakhs and 10 lakhs. The above courses are offered at much cheaper prices in government institutions, whose numbers and seats are very limited. Hence, many nursing aspirants have to avail courses in private colleges.

[39] Interview with Kakoli Mitra, owner of a private nursing home in Berhampore, Murshidabad on 15.09.21.
[40] Based on a series of interviews with J. Thomas, Ranita Raju, Mary Joseph, Praful Reddy, Mitra Barman in Kolkata between September 2019- February 2020.

All the fourteen GNM nurses working in the private sector, in their response had stated that they had completed their education from private institutions and in doing so they had to take loan from either the bank, money lender or relatives. Four of the interviewed nurses currently working in government hospitals, who had completed their studies in private institutions in Tamil Nadu and Andhra Pradesh had narrated similar tales. After spending so much effort, time and money, salary in the private sector is abysmally low. On top of it, however low paying the jobs they might have, women have to send home money, thus making their existence, a hand to mouth one. Hence, women migrate for dignity, better working and living conditions and better salaries (Nair 2012; Nair and Rajan 2017; Adhikari 2020). As one migrant Filipino nurse had responded in Catherine Cenzia Choy's work (2003) with regard to their pay and status in USA, "The work and salary equalizes. Your status becomes lost (sic)". What becomes apparent is that the nurses' families play a significant role in the well-planned process of enrolling in a nursing institution, graduating from it, going to a city like Kolkata, Delhi, Mumbai and then travelling abroad (Basu 2018).

In an informal interview with the Head of HR, Mr. Durganath Mitra[41], of an old private hospital, managed by one of India's biggest and oldest business groups in Kolkata, it was revealed that when hospitals require nurses, they occasionally contact recruiters or agencies or directly contact various nursing colleges across the country. On other occasions, a large group of nurses from a specific area travel in search of employment with an agency, and if there are openings, they are hired. M.Sc., B.Sc. nurses and a certain percentage of GNM nurses are hired directly by the hospital. However, most of the ANMs and a considerable number of GNMs are increasingly being hired through various agencies. This means, hospitals are maintaining a bare minimum staff pattern, for which the hospital is directly responsible. For those few workers, the pay scales are better, their jobs are relatively more secure, they have access to fully paid or half paid maternity leaves and other benefits like Employees Provident Fund (EPF) etc.

The agencies enter into a contract with the hospital on one hand and with the nurses on the other. Their salaries and benefits are not the concerns of the said hospital but of the agency. *Ayah*s are also employed by the hospital in a variety of positions, but their names are not shown on the payroll. In 2016, when the interview was conducted, sixty-five per cent of nurses came

[41] Interviewed on 15.09.16 in Kolkata.

from Kerala and Andhra Pradesh. Mr. Mitra had pointed out that the trend was, after gaining experience of two or three years, nurses working in Kolkata hospitals (mostly private), tend to move to Dubai, Abu Dhabi or Malaysia, which were sought after destinations for nurses working in the above hospital. After a few more years of moving to Dubai or Abu Dhabi, they would try moving to Canada, the US or Europe, which Mr. Mitra referred to as 'their ultimate dream' (Ibid). States might favour migration of nurses as it ensures flow of remittances back to the source countries (Sassen 2008) and as one manager of a nursing agency, pointed out, women migrant workers like nurses, are more likely to send back money for their families.

As is evident from the discussion above regarding poor pay structure in private healthcare sector in West Bengal, the migration of nurses to Kolkata or Siliguri cannot be attributed to the quest for better pay and lifestyle opportunities. As per a report, Tamil Nadu and the north-eastern states (other than Assam) are at the intermediate level, while West Bengal is at the "poor level", placing Kerala much ahead of West Bengal. Most of the time, migrant nurses see Kolkata as a stopover or "transit point"[42]. As nurses gain more expertise, they get more negotiating power, should they decide to return to the hospitals in their home states or relocate to USA, UK or South-East Asia (Institute of Applied Manpower Research 2011; Basu 2018). Based on interviews, it also became apparent that most hospitals in Kerala do not hire nurses without two years of experience, hence nurses fresh out of colleges come to West Bengal, where there is always a need for nursing personnel.

In an informal interview with the Principal of the College of Nursing, associated with a government medical college in Kolkata[43], it was revealed that though women come to government nursing colleges to pursue PG diploma or M.Sc. courses from outside West Bengal, it is difficult for them to find employment in government hospitals, as fluency in *Bangla* and *Nepali* languages is a must. Thus, if they have to find employment in Kolkata or in West Bengal, then private hospitals are the places they can find employment. Nurses working in government hospitals are mainly from different parts of West Bengal. An interview with a nurse affiliated to West Bengal Nurses Association[44] brought to light that nurses originating from West Bengal, but who had pursued nursing degree from elsewhere can also seek employment in government hospitals. However, they would need to apply for registration with

[42] Even Sreelekha Nair (2012) in her work had showed how Malayali nurses treated Delhi as a transit.
[43] Interview held on 23.06.17, in Kolkata.
[44] Interview held on 20.06.17, in Kolkata.

the West Bengal Nursing Council (WBNC), for which they would require a "still working" certificate from a private hospital in which she might have sought temporary employment. At the end of the process, the nurses would need to have 'reciprocal registration' certificate from WBNC, after which they can apply for government positions. However, the above process leaves the private hospitals in a vulnerable position as nurses treat them as stop-gap arrangements. On the other hand, hospital managements also know of these incidents, which give them an upper hand while negotiating their salary.

## 5.9 Duties and responsibilities of nurses:

Based on interviews a rough idea was formed which was later tallied with nursing manuals. Nurses are required to work in a variety of settings, including regular wards, emergency rooms, and operating rooms. The obligations and responsibilities of nurses are determined by their training and professional background. At the entry level, they are responsible for taking care of patients at the bedside, whereas at the senior level, they are in charge of managing particular populations, such as patients in intensive care, who need specialised training. Nurses' duties and responsibilities have been clubbed and categorised in the following manner.

### *5.9.1 Patient Care and Ward Related Duties and Responsibilities:*

It is the duty of nurses to ensure patient's safety and comfort. Hence, after determining patient's needs, nurses plan appropriate care for them after consulting with ward sisters. Nurses are responsible for providing direct patient care like bed-making, bathing, hair washing etc., in other words, fulfilling basic hygiene and nutritional needs of the patients is the duty of a staff nurse. The ward sister, on the other hand, as per hospital rules needs to plan and organise all nursing activities in her unit (ward) to facilitate patient care.

Staff nurses before joining their shift should collect notes regarding each patient from the nurse in the previous shift. She should also prepare notes, which should be handed over to her colleague in the next shift. Ward sister receives reports by staff nurses on patients, and sign those. She also makes bed to bed service in her department with staff nurses and students. If necessary, she provides direct care to seriously ill patients, or while handling an emergency or crisis like situation.

Staff nurses are required to assist in the process of admission, discharge and transfer of patients, prepare and assist in diagnostic procedures and collect medical history from the patients and

maintain detailed records of the same. Further, on getting written orders from medical officers or other relevant authorities' intra-vascular injections and intra-venous injections through IV channel can be administered by them. Ward sisters maintain all records of the patients, supervise their diets, and help the nurses to carry out instructions of physicians better. They also assign duties to staff nurses and nursing students based on the seriousness of the patient. For instance, minor post-operative care cases might get assigned to the final year students. Ward sisters also coordinate with other departments for the welfare and care of the patients. For example, if a patient in the orthopaedic department after surgery requires an X-ray to be done, it is their responsibility to coordinate with the radiology department and ensure that the procedure has been completed.

### *5.9.2 Supervisory work:*

In maintaining clean and hygienic environment, staff nurses might be required to provide supervision to ancillary staff and Group D staff and should also keep the belongings of the patients in safe custody. The ward sisters ensure cleanliness of the ward, with the help of assistant superintendent and ward masters. They check on the attendance of all nurses posted in their unit, and report the same to the office of the nursing superintendent. All ward supplies, equipment, medicines are handed over to them, which requires them to create an inventory and keep stock of items used or required by their respective wards. Thus, the maintenance of a log book is their responsibility. They also supervise the waste management of their wards, and prevent misuse of supplies. They are required to act as liaison officer between the ward and administration. Any kind of adverse situation, emergencies or crises should be primarily managed by them and reported to the relevant higher authority through nursing superintendent. They further write performance report for staff nurses and evaluate performance of students in their wards, and make reports accordingly.

### *5.9.3 Duties and Responsibilities of Nurses Regarding OT, ICU and other such units:*

Staff nurses in charge of Operation Theatre and ICU, or such other units, have the responsibility of checking the availability of Oxygen, Nitrogen Oxide, trolley, emergency medicines etc. They need to prepare the trolley according to Operation list, sanitise instruments and equipment like gloves and gauge and other tools, maintain clean aseptic environment, and check all electronic tools before the commencement of operation. They are also required to assist surgeons and anaesthetics in the Operation Theatre. In the absence of any designated Operation

Theatre sister or nurse, staff nurse can act as a substitute. They are also needed to fumigate OT room, closely monitor the condition of the patient during and after operation, keep stock of the instruments in the OT.

While providing maternal and child healthcare, nurses should be involved in antenatal, intra-natal and post-natal stages. They should assess the progress of labour and conduct normal delivery and provide care to the new-born. In case of ICUs and other special units, apart from supervising sanitising work, they are additionally required to check monitors, ventilators and all other lifesaving gadgets.

### *5.9.4 Education and Training Related Work:*

Staff nurses are required to assign nursing students to patients keeping in mind their level of knowledge and would supervise the care being administered by the students. The nurses would guide them about nursing procedures; help the students by participating in clinical teaching programmes. The performance reports of the nursing students are maintained by the ward sisters. They are also responsible for organising orientation programmes, workshops and seminars for both staff and students[45]. Both nurses and staff nurses are also expected to help in various research endeavours whenever possible, to improve academic rigour.

Nowadays, nurses are also burdened with other non-nursing activities like looking after billing, record keeping, inventory, etc., leaving less time for patient care (Chhugani and James 2017, 113). Several respondents, in this research had also revealed that in order to prevent any scope for any error on the part of the administration, they have to prepare copious reports before admitting a patient, while handing over charge after shift end or before release or transfer of a patient. Anu Jacob, a recent pass out from a private nursing college in Thrissur, Kerala, working in a hospital in Salt Lake stated that nurses also have to help in the front desk of the hospital or in the cash section, when the hospital is understaffed or overcrowded. 'Often it gets difficult to reach insurance companies, in such moments we have to constantly counsel patient's families so that they do not get angry or tensed', she added[46]. Thus, due to an increase in non-nursing activities, other categories of careworkers, like bedside nurses, nursing aides or even *ayahs* are becoming necessary for providing direct care in institutional settings.

[45] Interview with Deputy Nursing Superintendent associated with a medical college and hospital located in Kolkata on 23.09.16; interview with Principal of school of nursing attached with a medical college and hospital located in Kolkata on 23.09.16. Also see circular no. HNG/6M-7-2013/742 dated 20.05.2013, Directorate of Health Services, Government of West Bengal.

[46] Interview conducted on 05.06.19 in Salt Lake, Kolkata.

## 5.10 Responses:

*Table 2*: Sample of responses

| Designation of nurses | Government Sector | | Private Sector | |
|---|---|---|---|---|
| | Regular | Contractual | Regular | Contractual |
| M Sc. Nurses/ Ph.D. | 3 (1 Principal) | | 1(Tutor) | |
| B Sc. Nurses and post-basic nurses | 8 | | 2 | |
| GNM nurses | 14 | | 4 | 10 (2 Male) |
| ANM nurses | 4 | 4 (ANMII) | - | 18 |
| Interns/Students | 3 | | 3 | |
| Bedside nurses | - | - | - | 10 |
| Total | 85 | | | |

Most of the respondents had claimed to have joined nursing profession in order to become financially independent. The only two male respondents had stated that they chose nursing as they could not qualify for studying medicine and eventually become doctors. Seven respondents claimed to have joined nursing, because they aspired to become nurses since childhood as there was someone in their families who was or still is a nurse. Another 11 respondents claimed that they became nurses as their parents wanted them to choose this profession. When questioned about the behaviour of their colleagues, 25 nurses responded it to good, while 42 claimed it was okay and 2 male nurses expressed that it was bad. One felt that their gender made them stick out. While he got along well with their colleagues who are of the same age, he faced problems while interacting with senior nurses and doctors. 'The perception being that since I was not good enough a student to become doctor, I am not a good nurse'[47]. The other one claimed that in two years' time, he would go to Australia and settle down there. In total 12 nurses, (all working in the private sector) had acknowledged that they are preparing to migrate for better job opportunities, better pay and better life. It is also worth mentioning that all 6 interns and 10 bedside nurses did not respond to the above question.

When asked about patient party's behaviour, 5 nurses working in government district hospitals said it was good. 2 others working at the community level also expressed the same. However, among the rest a minority suggested it was bad, while the rest were okay about it. In the private

[47] Interviewed on 14.07.18 in Salt Lake, Kolkata.

sector, all nurses, except for three, said that the patient party's behaviour was good. Further, while nurses in cities had access to changing rooms and clean and proper washrooms, a separate changing room was not available in small cities or in rural areas. Bedside nurses in private hospitals in Kolkata reported to use the common washroom and claimed changing clothes in them as well. Nobody told them if they could use the ones meant for the nurses and they also did not have the courage to ask.

Further, a majority of nurses working in the government hospitals (total 20), had stated that there has been an improvement of healthcare services in recent times, as access has increased. 'Under the present government, recruitments are being done regularly. However, there was a time under the Left -Front when due to complex recruitment process, regular recruitments could not be made. Further, with more healthcare centres being set up in rural areas, small towns, people are getting access to healthcare at subsidised rate, no doubt,' pointed out Narayani Sen[48], associated with West Bengal Nurses Association. However, she also cautioned, that she was aware that in many of such newly set up centres, there is dearth of infrastructure and that the path to equity in healthcare is a long one. Similar response was also recorded from the private sector. Nurses expressed content that new healthcare centres were cropping up, however, unless their work conditions, or pay structures improved, such development was meaningless for them.

2 young bedside nurses expressed that they want to become doctors, little realising that such can never happen. Similarly, middle aged ANM nurses working in private nursing homes in West Midnapore expressed their desire to become GNM nurses. That young women lack proper guidance became evident from the above declarations. While for one section of nurses, the sky is the limit, but for the others, their dreams of climbing up the ladder seems like a mirage in a desert.

## 5.11 Collective Claim Making:

To what extent can nurses challenge or go against the authorities, with which they are vested, asked Rafferty, Robinson and Elkan (1997, 3) in their edited volume. The question stems from the general perception regarding nurses and nursing profession. Many believe that nursing is not an independent profession, and they are viewed as subordinates of the doctors who provide

[48] Interviewed on 13.07.18 in Jadavpur, Kolkata.

medical care (López-Deflory, Perron and Miró-Bonet 2021). There is however a difficulty in establishing carework within the ambit of labour or work. Labour or work is generally associated with the industrial workers or the working class, hence carework gets ignored. Generally speaking, one's understanding of claim making, centres around the organised sector and unions. Hence the demands of nurses who are not unionised ( respondents from Manipur working in private hospitals in Kolkata reported not being part of unions) often gets stifled (Oomem 2009, 81).

One of the oldest nursing organisations of nurses, the Trained Nurses Association of India (TNAI) has long back taken the official stand on not resorting to strikes as a way of claim making (TNAI 2001; Healey 2013), perhaps in an effort to prevent any possibility of disengaging the idea of 'service' associated with nursing. There are various unions or associations for government sector nurses, many of which are affiliated to political parties while there are some that claim to be non-partisan. However, associations in the private sector, has been a relatively new phenomenon. Following the suicide of Beena Baby, a registered staff nurse, who was working in Mumbai, but was originally from Kerala, a wave of protests had spread to various cities in India. The protests led by nurses had condemning the exploitative tendencies of private hospitals and the absence of government laws regulating this sector. The United Nurses Association was formed in Kerala and later opened branches in other cities[49] in 2011, in response to Beena Baby's suicide.

Government nurses are overburdened with work with an uncertainty lurking regarding the possibility of being transferred to a place away from family. In case of private sector nurses there are different uncertainties regarding contract renewal, salary up-gradation, freedom from touts etc. However, despite such uncertainties, nurses have challenged the management of private sector hospitals, for instance, in 2011 after Beena Baby's death (Mathew 2011), when they had complained and participated in strikes alleging that they were getting less salary than promised by a big private hospital along Eastern Metropolitan Bypass. Similarly, government nurses have also voiced dissent against the minister in charge of the department of health and family welfare from time to time, with them calling out pay disparity and whimsical transfer policies recently (*The Telegraph*, August 3, 2021). It needs mentioning that most of the nurses interviewed in the government sector are members of Nurses Unity (a non-partisan nursing Association), currently championing the cause of pay disparity and most of the Malayali nurses

[49] For details see https://www.unaworld.org/nurses-registration/. Last accessed 23.09.21.

interviewed and two nurses from Odisha are associated with United Nurses Association (West Bengal chapter).

## 5.12 Towards Dignity?

It becomes obvious that the pay and terms and conditions of work are better in government hospitals of West Bengal, when compared to private hospitals, which are nothing short of exploitative. But even the nurses in the government sector have been protesting against pay disparity since 2019. Other government employees with similar degrees get better pay grades, the nurses had alleged (*The Telegraph*, August 3, 2021; *The Telegraph*, August 4, 2021; *Deccan Herald* August 25, 2021). 'How one's work is perceived depends on the salary one is getting. It is certainly important for us because our work gets trivialised everyday', admitted one of the protesting nurses in Kolkata[50]. Despite allegations of pay disparity, a sizeable section of nurses working in private hospitals in Kolkata took employment in government hospitals during the on-going pandemic around September, 2020. In an interview with Sahanara Begum (associated with a government hospital in Kolkata), she had stated that the poor terms and conditions of the service of nurses in private hospitals was exposed during the pandemic and the nurses in search for security and better protection opted for government facilities. If news reports are to be believed as many as six hundred nurses shifted to government hospitals for work (TOI November 3, 2020).

The reason for pay disparity in government sector and low pay structure in the private sector can be located in how the work of nurses is perceived. Women's labour, especially women's reproductive labour (or commodified reproductive labour like nursing), has not been given due attention, even while studying women as part of the paid work-force (Duffy 2007). Nursing stands at the point of interjection between reproductive and productive labour. This, along with Brahminical patriarchy lends a low status to the profession. That nurses have to interact with male colleagues or touch male patients is also not appreciated in Indian societies (Reddy 2015, 4; Healey 2013). Additionally, research has concentrated more on women's admission into "male domains" than it has on occupations where women have always held the majority, such as nursing. The names of pioneering Indian nurses like Margaret Dean and Reena Bose, who had worked in the field for over five decades, are not mentioned in any academic discourses or

[50] Telephonic interview conducted on 25.09.21.

activist memoirs, in contrast to Haimavati Sen and Anandibai Joshi, both of whom were doctors and much celebrated in research and other forms of writing (Baer 1997,244; Nair 2012, 1).

Though policy documents have addressed nursing profession by allotting funds for nurses' training, deployment etc., they have seldom addressed real problems like lack of housing, gender-based harassment at workplaces, absence of separate washrooms for female careworkers in remote areas, transfer policies, understaffing in rural areas and so forth, do not get addressed. Questions only get raised in legislative assemblies if nurses protest for a long time, but then again, reaching for permanent solutions take up a long time. When Mamata Banerjee's Trinamool Congress formed government in 2011, a circular[51] was issued to take stock of the existing health condition of the state. It was both meant for officials of the department of health and family welfare as well as for private sectors. A questionnaire was also circulated in August , 2011 regarding what new things could be undertaken, how much work was pending and so on. Though the questionnaire aimed at gathering information about the nursing profession as well, it was limited to their numbers, availability area wise, number of training institutions etc. The new government could have used this opportunity to 'know' the problems women careworkers like nurses, face and negotiate with, on an everyday basis.

Though there are power dynamics at play between nurses and the patients, or between nurses and *ayah*s or nurses and General Duty Assistants (GDAs), there are other set of dynamics that nurses have to deal with on a daily basis. This includes interaction between nurses and Medical Superintendent cum Vice Principals (MSVP), union leaders of Group D staff (both permanent and contractual), local political party leaders, well connected patients' families and 'rowdy' members of patient party.

In India, there is a lack of independence associated with the nursing profession. The gendered nature of the work may pose a challenge as to how the profession is perceived and practiced (and to what extent autonomy exists). For instance, independent nurse prescribers can legally prescribe medicines within their respective specialised area in UK (Avery and James 2007, 316). In countries like Canada, USA, Australia, advance practice nurses (APNs) with master's degree can prescribe medicines (Maier 2019, 2), but despite getting specialised training after their B.Sc. nursing degrees and after years of experience, Indian nurses cannot even prescribe Paracetamol for fever. That the government of West Bengal had decided to create posts for practitioner sister who would be able to prescribe medicines for common illness, after

[51] See document HF/O/P&B/47/3C-6/2011-12, Swasthya Bhawan, Kolkata.

undergoing a course (*The Telegraph*, August 27, 2021; The Times of India, August 27, 2021) was welcomed by most of the respondents. At a time when nurses are already protesting against pay disparity, this decision might be construed by critics as a strategy to appease protesting nurses. Huda Begum, associated with one of the non-partisan nursing organisations for government nurses, fighting for the cause of pay parity had stated, 'This and uniform pay structure is what can give our work, basic dignity'[52].

If the above is the situation for nurses, who are trained careworkers, having a certain amount of socio-economic status in society, helping to realise the goals set forward by various healthcare policies, it is important to pay attention to the conditions of another category of careworkers who might be perceived as the 'underbelly' of care – the *ayahs*.

[52] Telephonic interview conducted on 26.11.21.